

ORIGINAL

IN THE DISTRICT COURT WITHIN AND FOR TULSA COUNTY
STATE OF OKLAHOMA

DISTRICT COURT
FILED

ANGELIA ANDREWS an individual
resident of Tulsa County, Oklahoma,
plaintiff,

versus

**LIFE INSURANCE COMPANY OF
NORTH AMERICA**, a foreign (non-
Oklahoma) insurance company registered
to do business and in fact doing business
as "**Cigna**" throughout the State of
Oklahoma
defendant.

MAY 22 2017

DON NEWBERRY, Court Clerk
STATE OF OKLA. TULSA COUNTY

CASE NO. CJ-2017-895

Jury Trial Demanded

Attorneys Lien Claimed

AMENDED COMPLAINT

Comes now the Plaintiff, Dr. Angelia Andrews ("Dr. Andrews" or "Plaintiff"), by her attorney, JAMES W. DUNHAM, JR (OBA # 2532), and, for her complaint against the Defendant, Life Insurance Company of North America ("Cigna"), states:

Jurisdiction and Venue

1) Jurisdiction of this court is based upon the Employee Retirement Income Security Act of 1974 ("ERISA") and, in particular, 29 U.S.C. §§ 1132(a)(1) and 1132(e)(1). Those provisions give the this court jurisdiction to hear civil actions brought to recover benefits due under the terms of employee welfare benefit plans, which, in this particular case, consists of a group-long term disability ("LTD") insurance policy ("the Policy"), Policy # LK-963732, underwritten and administered by Cigna, for the benefit of employees of Jackson County Memorial Hospital, which includes Plaintiff.

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2) The ERISA statute provides, at 29 U.S.C. § 1133, a mechanism for administrative or internal appeal of benefit denials. Plaintiff has duly exhausted all such avenues for her claim and appeal.

3) Venue is proper in the this Court since Defendant does business in this county and Plaintiff resides in this county. 29 U.S.C. § 1132(e)(2); 28 U.S.C. § 1391.

Nature of the Action

4) This is a claim seeking recovery of disability benefits claimed under an employee welfare benefit plan (“the Plan”), which provided insured long-term disability insurance benefits under group policy number GLT-675999 (“the Policy”), issued by Cigna to Jackson County Memorial Hospital (a true and accurate copy of the certificate of insurance is attached hereto as Exhibit “A” and by that reference incorporated herein). This action is brought pursuant to ERISA § 502(a)(1)(B) (29 U.S.C. § 1132(a)(1)(B)). Plaintiff also seeks attorneys’ fees pursuant to 29 U.S.C. § 1132(g) and ERISA § 502(g).

The Parties

5) Plaintiff, age 56 (born in 1961), is a natural person residing in Tulsa County, Oklahoma.

6) Defendant, Cigna, has at all times relevant hereto done business throughout the United States and within Tulsa County, Oklahoma, and issued and delivered insurance coverage to Plaintiff and her employer in the State of Oklahoma.

7) Cigna is a named fiduciary and is the claims administrator for the Plan.

Statement of Facts

8) Prior to the onset of her claimed disability on April 11th, 2014, Plaintiff was employed on a full-time basis as a family practice physician for Jackson County Memorial Hospital (“Plaintiff’s Employer”).

9) At all times relevant hereto, Plaintiff's Employer maintained the Plan, an ERISA-qualified benefits plan for its employees, which included income replacement benefits ("LTD") for employees that became disabled as defined by the Plan.

10) On April 10th 2014, Andrews ceased working on account of degenerative disc disease, spinal stenosis, cervicgia and related medical conditions for which she has undergone multiple surgeries, extensive medical treatment and necessarily-aggressive (yet closely monitored) pain management.

11) The Policy provides:

Definition of Disability/Disabled

The Employee is considered Disabled if, solely because of injury or Sickness, he or she is:

1. unable to perform the material duties of his or her Regular Occupation; and
2. unable to earn 80% or more of his or her Indexed Earnings from working in his or her Regular Occupation.

After Disability Benefits have been payable for 60 months, the Employee is considered Disabled if, solely due to Injury or Sickness, he or she is:

1. unable to perform the material duties of any occupation for which he or she is, or may reasonably become, qualified based on education, training or experience; and
2. unable to earn 80% or more of his or her Indexed Earnings.

12) After Andrews ceased working, and following a six-month elimination period, she properly submitted a claim for disability benefits pursuant to the Plan. In late 2014, Cigna determined that she was disabled under the terms of the policy as stated above ("unable to perform the material duties of... her Regular Occupation"), approved her application for disability benefits and commenced making payments to her in the monthly sum of \$5,000.00 (subject to certain offsets).

13) Cigna specifically acknowledged that the medical condition disabling Plaintiff, as defined in the Policy, was "Cervicgia", though her condition has also, at times, been referred to by Cigna, Plaintiff's health care providers, and even Plaintiff herself, as "Spinal Stenosis",

“Stenosis”, “Degenerative Disc Disease”, “Cervical Disc Displacement”, “Failed Back Syndrome” and similar references.

14) The above-referenced monthly payments continued into the Spring of 2016, when Cigna informed Plaintiff that her disability status was under review in anticipation of the Policy’s definitional change from “unable to perform the material duties of... her Regular Occupation” to “unable to perform the material duties of any occupation for which... she is, or may reasonably become, qualified based on education, training or experience”.

15) More than three months before the definitional change went into effect, by a letter dated June 16th, 2016 (“the First ABD”¹, received by Plaintiff June 21st, 2016), Cigna informed Plaintiff that it was terminating her disabled status effective October 8th, 2016, contending that she was able to perform the duties of an “M.D. Consultant”. See Exhibit B attached hereto.

16) Cigna prepaid Plaintiff’s remaining LTD benefits for the period of time up to the termination date it had determined, October 8th, 2016, and stated no further benefits were payable thereafter.

17) Consistent with her Plan rights and obligations, Plaintiff administratively appealed (“the First Appeal”) the First ABD.

18) By letter dated January 30th, 2017 (“the Second ABD”), with no discussion whatsoever, Cigna overturned the First ABD out of hand, completely abandoning its position that Plaintiff was able to perform the duties of an “M.D. Consultant”. See Exhibit C attached hereto.

19) Rather than reinstating her benefits, though, the Second ABD contended that Plaintiff’s disability was, and had since the inception been, a “mental or nervous disorder” subject to the Policy’s two-year benefits limitation that reads as follows:

¹ “ABD” is an ERISA-specific acronym for “Adverse Benefit Determination”.

Limited Benefit Periods for Mental or Nervous Disorders

The Insurance Company will pay Disability Benefits on a limited basis during an Employee's lifetime for a Disability caused by, or contributed to by, any one or more of the following conditions. Once 24 monthly Disability Benefits have been paid, no further benefits will be payable for any of the following conditions.

- 1) Anxiety disorders
- 2) Delusional (paranoid) disorders
- 3) Depressive disorders
- 4) Eating disorders
- 5) Mental illness
- 6) Somatoform disorders (psychosomatic illness)

If, before reaching his or her lifetime maximum benefit, an Employee is confined in a hospital for more than 14 consecutive days, that period of confinement will not count against his or her lifetime limit. The confinement must be for the Appropriate Care of any of the conditions listed above. "

20) Retroactively applying this language and it's false determination that Plaintiff's disability was and always had been a "mental or nervous disorder", the Second ABD contended that Cigna had already paid Plaintiff the maximum benefits to which she was entitled (except for the period between October 8th, 2016 and October 22nd, 2016 – the latter date, not coincidentally, being the true 24-month anniversary of the LTD benefit period for which benefits were allowed), leaving intact the First ABD's termination of her benefits, albeit on entirely new grounds.

21) Plaintiff administratively appealed the Second ABD ("the Second Appeal").

22) Having not been timely adjudicated by Cigna within the time allowed by law, the Second Appeal is deemed denied.

First claim for relief – 29 U.S.C. § 1132(a)(1)(B) – Breach of Contract – Reinstatement of LTD Benefits

23) Cigna's Second ABD, it's determination that Plaintiff suffered from a "mental disorder" as defined in the policy, that her LTD benefits theretofore paid were on account of a "mental disorder" and its resulting termination of her LTD benefits:

- a. Are unsupported by substantial evidence;

- b. Are biased in every material respect;
- c. Have no legitimate legal or factual basis, and;
- d. Are arbitrary and capricious as a matter of law.

24) Therefore, this Court should overturn Cigna's termination of Plaintiff's LTD benefits as stated in the Second ABD and to reinstate her benefits effective October 22nd, 2016, for interest from that date to the date of judgment and post-judgment as allowed by law, for costs and attorney's fees, also as allowed by law, and any and all further relief to which this Court may deem her entitled.

Second claim for relief – 29 U.S.C. § 1132(a)(1)(B) – Declaratory Judgment

25) By denying Plaintiff's First Appeal on grounds not asserted in the First ABD, Cigna violated ERISA's procedural requirements, depriving her of the full and fair review (of the First ABD) to which she was (and is) entitled.

26) To mitigate Plaintiff's damages resulting from said deprivation, this Court should enter a declaratory judgment determining that:

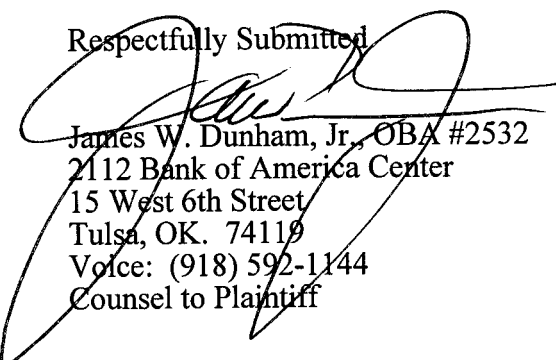
- a. Cigna's Second ABD failed to adequately address the issues raised by Plaintiff's First Appeal;
- b. Cigna's Second ABD denied Plaintiff a full and fair review of the First Appeal;
- c. Cigna's Second ABD constitutes a final and binding abandonment of the position asserted in the First ABD to the effect that Plaintiff is able to perform the material duties of some (any) occupation for which she is, or may reasonably become, qualified based on education, training or experience.
- d. Cigna is estopped from arguing or presenting any proof that, as of February 14th, 2017, Plaintiff was then able to perform the material duties of some (any)

occupation for which she is, or may reasonably become, qualified based on education, training or experience.

WHEREFORE, Plaintiff prays that this Court:

- A. Estop Cigna from asserting, arguing or offering any evidence to the effect that Plaintiff, as of February 14th, 2017, was:
 - a. able to perform the material duties of any occupation for which she was, or might have reasonably become, qualified based on education, training or experience or
 - b. able to earn 80% or more of her Indexed Earnings, as that term is defined in the Policy;
- B. Judicially declare that, as of February 14th, 2017, Plaintiff was:
 - a. unable to perform the material duties of any occupation for which she was, or might reasonably have become, qualified based on education, training or experience; and
 - b. unable to earn 80% or more of her Indexed Earnings, as that term is defined in the Policy;
- C. Overturn Cigna's termination of her LTD and reinstate them retroactively to October 23rd, 2016, as follows;
 - a. Order Cigna to pay her all LTD benefits accruing from October 23rd, 2016 to the date of Judgment in a single payment;
 - b. Order Cigna to pay benefits accruing after the date of judgment in the form monthly payments as contemplated by the Policy;
- D. for pre and post judgment interest at the applicable, and;
- E. for her costs and attorneys fees
- F. For any and all additional or further relief to which the Court may deem her entitled.

Respectfully Submitted



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(800) 732-1603 TDD (800) 552-5744
A STOCK INSURANCE COMPANY

GROUP POLICY

POLICYHOLDER: Jackson County Memorial Hospital
POLICY NUMBER: LK-963732
POLICY EFFECTIVE DATE: May 1, 2013
POLICY ANNIVERSARY DATE: May 1

This Policy describes the terms and conditions of coverage. It is issued in Oklahoma and shall be governed by its laws. The Policy goes into effect on the Policy Effective Date, 12:01 a.m. at the Policyholder's address.

In return for the required premium, the Insurance Company and the Policyholder have agreed to all the terms of this Policy.



Scott Kern, Corporate Secretary



Matthew G. Manders, President

TL-004700

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SCHEDULE OF BENEFITS

Premium Due Date: The last day of each month

Classes of Eligible Employees

On the pages following the definition of eligible employees there is a Schedule of Benefits for each Class of Eligible Employees listed below. For an explanation of these benefits, please see the Description of Benefits provision.

If an Employee is eligible under one Class of Eligible Employees and later becomes eligible under a different Class of Eligible Employees, changes in the Employee's insurance due to the class change will be effective on the first date the Employee is in Active Service on or after the date of the change in class.

- | | |
|---------|---|
| Class 1 | All active, Full-time or part-time Employees of the Employer classified as Executive, regularly working a minimum of 20 hours per week. |
| Class 2 | All active, Full-time or part-time Employees of the Employer regularly working a minimum of 20 hours per week, excluding Employees classified as Executive. |

SCHEDULE OF BENEFITS FOR CLASS 1

Eligibility Waiting Period

For Employees hired on or before the Policy Effective Date: No Waiting Period

For Employees hired after the Policy Effective Date: No Waiting Period

Definition of Disability/Disabled

The Employee is considered Disabled if, solely because of Injury or Sickness, he or she is:

1. unable to perform the material duties of his or her Regular Occupation; and
2. unable to earn 80% or more of his or her Indexed Earnings from working in his or her Regular Occupation.

After Disability Benefits have been payable for 60 months, the Employee is considered Disabled if, solely due to Injury or Sickness, he or she is:

1. unable to perform the material duties of any occupation for which he or she is, or may reasonably become, qualified based on education, training or experience; and
2. unable to earn 80% or more of his or her Indexed Earnings.

The Insurance Company will require proof of earnings and continued Disability.

Definition of Covered Earnings

Covered Earnings means an Employee's wage or salary as reported by the Employer for work performed for the Employer as in effect just prior to the date Disability begins. Covered Earnings are determined initially on the date an Employee applies for coverage. A change in the amount of Covered Earnings is effective on the date of the change, if the Employer gives us written notice of the change and the required premium is paid.

It does not include amounts received as bonus, commissions, overtime pay or other extra compensation.

Any increase in an Employee's Covered Earnings will not be effective during a period of continuous Disability.

Elimination Period	180 days
Gross Disability Benefit	The lesser of 60% of an Employee's monthly Covered Earnings rounded to the nearest dollar or the Maximum Disability Benefit.
Maximum Disability Benefit	\$5,000 per month
Minimum Disability Benefit	The greater of \$100 or 10% of an Employee's Monthly Benefit prior to any reductions for Other Income Benefits.

Disability Benefit Calculation

The Disability Benefit payable to the Employee is figured using the Gross Disability Benefit, Other Income Benefits and the Return to Work Incentive. Monthly Benefits are based on a 30-day month. The Disability Benefit will be prorated if payable for any period less than a month.

During any month the Employee has no Disability Earnings, the monthly benefit payable is the Gross Disability Benefit less Other Income Benefits. During any month the Employee has Disability Earnings, benefits are determined under the Return to Work Incentive. Benefits will not be less than the minimum benefit shown in the Schedule of Benefits except as provided under the section Minimum Benefit.

Initial Premium Rates

\$.45 per \$100 of Covered Payroll

Covered Payroll for an Employee will mean his or her Covered Earnings for the insurance month prior to the date the determination is made. However, an Employee's Covered Payroll will not include any part of his or her monthly Covered Earnings which exceed \$8,333.

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SCHEDULE OF BENEFITS FOR CLASS 2

Eligibility Waiting Period

For Employees hired on or before the Policy Effective Date:	After 12 months of Active Service
For Employees hired after the Policy Effective Date:	After 12 months of Active Service

The *Eligibility Waiting Period* does not apply if a former Employee is rehired within 12 months after termination date and had satisfied the *Eligibility Waiting Period* prior to termination date. If Employee did not fully satisfy the *Eligibility Waiting Period* prior to termination date, credit will be given for any time that was satisfied.

Definition of Disability/Disabled

The Employee is considered Disabled if, solely because of Injury or Sickness, he or she is:

1. unable to perform the material duties of his or her Regular Occupation; and
2. unable to earn 80% or more of his or her Indexed Earnings from working in his or her Regular Occupation.

After Disability Benefits have been payable for 24 months, the Employee is considered Disabled if, solely due to Injury or Sickness, he or she is:

1. unable to perform the material duties of any occupation for which he or she is, or may reasonably become, qualified based on education, training or experience; and
2. unable to earn 80% or more of his or her Indexed Earnings.

The Insurance Company will require proof of earnings and continued Disability.

Definition of Covered Earnings

Covered Earnings means an Employee's wage or salary as reported by the Employer for work performed for the Employer as in effect just prior to the date Disability begins. Covered Earnings are determined initially on the date an Employee applies for coverage. A change in the amount of Covered Earnings is effective on the date of the change, if the Employer gives us written notice of the change and the required premium is paid.

It does not include amounts received as bonus, commissions, overtime pay or other extra compensation.

Any increase in an Employee's Covered Earnings will not be effective during a period of continuous Disability.

Elimination Period	180 days
Gross Disability Benefit	The lesser of 60% of an Employee's monthly Covered Earnings rounded to the nearest dollar or the Maximum Disability Benefit.
Maximum Disability Benefit	\$5,000 per month
Minimum Disability Benefit	The greater of \$100 or 10% of an Employee's Monthly Benefit prior to any reductions for Other Income Benefits.

Disability Benefit Calculation

The Disability Benefit payable to the Employee is figured using the Gross Disability Benefit, Other Income Benefits and the Return to Work Incentive. Monthly Benefits are based on a 30-day month. The Disability Benefit will be prorated if payable for any period less than a month.

During any month the Employee has no Disability Earnings, the monthly benefit payable is the Gross Disability Benefit less Other Income Benefits. During any month the Employee has Disability Earnings, benefits are determined under the Return to Work Incentive. Benefits will not be less than the minimum benefit shown in the Schedule of Benefits except as provided under the section Minimum Benefit.

"Other Income Benefits" means any benefits listed in the Other Income Benefits provision that an Employee receives on his or her own behalf or for dependents, or which the Employee's dependents receive because of the Employee's entitlement to Other Income Benefits.

Return to Work Incentive

During any month the Employee has Disability Earnings, his or her benefits will be calculated as follows.

The Employee's monthly benefit payable will be calculated as follows during the first 24 months disability benefits are payable and the Employee has Disability Earnings:

1. Add the Employee's Gross Disability Benefit and Disability Earnings.
2. Compare the sum from 1. to the Employee's Indexed Earnings.
3. If the sum from 1. exceeds 100% of the Employee's Indexed Earnings, then subtract the Indexed Earnings from the sum in 1.
4. The Employee's Gross Disability Benefit will be reduced by the difference from 3., as well as by Other Income Benefits.
5. If the sum from 1. does not exceed 100% of the Employee's Indexed Earnings, the Employee's Gross Disability Benefit will be reduced by Other Income Benefits.

After disability benefits are payable for 24 months, the monthly benefit payable is the Gross Disability Benefit reduced by Other Income Benefits and 50% of Disability Earnings.

No Disability Benefits will be paid, and insurance will end if the Insurance Company determines the Employee is able to work under a modified work arrangement and he or she refuses to do so without Good Cause.

Additional Benefits*Survivor Benefit*

Amount of Benefit:	100% of the sum of the last full Disability Benefit plus the amount of any Disability Earnings by which the benefit had been reduced for that month.
Maximum Benefit Period	A single lump sum payment equal to 3 monthly Survivor Benefits.

Maximum Benefit Period

The later of the Employee's SSNRA* or the Maximum Benefit Period listed below.

Age When Disability Begins

Age 62 or under

Age 63

Age 64

Age 65

Age 66

Age 67

Age 68

Age 69 or older

Maximum Benefit Period

The Employee's 65th birthday or the date the 42nd Monthly Benefit is payable, if later.

The date the 36th Monthly Benefit is payable.

The date the 30th Monthly Benefit is payable.

The date the 24th Monthly Benefit is payable.

The date the 21st Monthly Benefit is payable.

The date the 18th Monthly Benefit is payable.

The date the 15th Monthly Benefit is payable.

The date the 12th Monthly Benefit is payable.

*SSNRA means the Social Security Normal Retirement Age in effect under the Social Security Act on the Policy Effective Date.

Initial Premium Rates

\$.45 per \$100 of Covered Payroll

Covered Payroll for an Employee will mean his or her Covered Earnings for the insurance month prior to the date the determination is made. However, an Employee's Covered Payroll will not include any part of his or her monthly Covered Earnings which exceed \$8,333.

TL-004774

ELIGIBILITY FOR INSURANCE

An Employee in one of the Classes of Eligible Employees shown in the Schedule of Benefits is eligible to be insured on the Policy Effective Date, or the day after he or she completes the Eligibility Waiting Period, if later. The Eligibility Waiting Period is the period of time the Employee must be in Active Service to be eligible for coverage. It will be extended by the number of days the Employee is not in Active Service.

Except as noted in the Reinstatement Provision, if an Employee terminates coverage and later wishes to reapply, or if a former Employee is rehired more than 12 months after his or her termination date, a new Eligibility Waiting Period must be satisfied. An Employee is not required to satisfy a new Eligibility Waiting Period if he or she is a former Employee and is rehired within 12 months of his or her termination date or insurance ends because he or she is no longer in a Class of Eligible Employees, but continues to be employed and within one year becomes a member of an eligible class

TL-004710

EFFECTIVE DATE OF INSURANCE

An Employee will be insured on the date he or she becomes eligible, if the Employee is not required to contribute to the cost of this insurance.

If an Employee is not in Active Service on the date insurance would otherwise be effective, it will be effective on the date he or she returns to any occupation for the Employer on a Full-time basis.

TL-004712

TERMINATION OF INSURANCE

An Employee's coverage will end on the earliest of the following dates:

1. the date the Employee is eligible for coverage under a plan intended to replace this coverage;
2. the date the Policy is terminated;
3. the date the Employee is no longer in an eligible class;
4. the day after the end of the period for which premiums are paid;
5. the date the Employee is no longer in Active Service;
6. the date benefits end for failure to comply with the terms and conditions of the Policy.

Disability Benefits will be payable to an Employee who is entitled to receive Disability Benefits when the Policy terminates, if he or she remains disabled and meets the requirements of the Policy. Any period of Disability, regardless of cause, that begins when the Employee is eligible under another group disability coverage provided by any employer, will not be covered.

TL-007505.00

CONTINUATION OF INSURANCE

This Continuation of Insurance provision modifies the Termination of Insurance provision to allow insurance to continue under certain circumstances if the Insured Employee is no longer in Active Service. Insurance that is continued under this provision is subject to all other terms of the Termination of Insurance provisions.

Disability Insurance continues if an Employee's Active Service ends due to a Disability for which benefits under the Policy are or may become payable. Premiums for the Employee will be waived while Disability Benefits are payable. If the Employee does not return to Active Service, this insurance ends when the Disability ends or when benefits are no longer payable, whichever occurs first.

If an Employee's Active Service ends due to an approved leave pursuant to the Family and Medical Leave Act (FMLA), insurance will continue up to the later of the period of his or her approved FMLA leave or the leave period required by law in the state in which he or she is employed. Premiums are required for this coverage.

If an Employee's Active Service ends due to any other leave of absence approved in writing by the Employer prior to the date the Employee ceases work, insurance will continue for an Employee for up to 14 day. Premiums are required for this coverage. An approved leave of absence does not include Furlough, Temporary Layoff or termination of employment.

If an Employee's Active Service ends due to Temporary Layoff, insurance will continue for an Employee until the end of the month in which the Temporary Layoff begins. Premiums are required for this coverage.

If an Employee's Active Service ends due to any other excused short term absence from work that is reported to the Employer timely in accordance with the Employer's reporting requirements for such short term absence, insurance for an Employee will continue until the earlier of:

- a. the date the Employee's employment relationship with the Employer terminates;
- b. the date premiums are not paid when due;
- c. the end of the 30 day period that begins with the first day of such excused absence;
- d. the end of the period for which such short term absence is excused by the Employer.

Notwithstanding any other provision of this policy, if an Employee's Active Service ends due to termination of employment or any other termination of the employment relationship, insurance will terminate and Continuation of Insurance under this provision will not apply.

If an Employee's insurance is continued pursuant to this Continuation of Insurance provision, and he or she becomes Disabled during such period of continuation, Disability Benefits will not begin until the later of the date the Elimination Period is satisfied or the date he or she is scheduled to return to Active Service.

TL-009970.00

TAKEOVER PROVISION

This provision applies only to Employees eligible under this Policy who were covered for long term disability coverage on the day prior to the effective date of this Policy under the Prior Plan provided by the Policyholder or by an entity that has been acquired by the Policyholder.

- A. This section A applies to Employees who are not in Active Service on the day prior to the effective date of this Policy due to a reason for which the Prior Plan and this Policy both provide for continuation of insurance. If required premium is paid when due, the Insurance Company will insure an Employee to which this section applies against a disability that occurs after the effective date of this Policy for the affected employee group. This coverage will be provided until the earlier of the date: (a) the employee returns to Active Service, (b) continuation of insurance under the Prior Plan would end but for termination of that plan; or (c) the date continuation of insurance under this Policy would end if computed from the first day the employee was not in Active Service. The Policy will provide this coverage as follows:

1. If benefits for a disability are covered under the Prior Plan, no benefits are payable under this Plan.
 2. If the disability is not a covered disability under the Prior Plan solely because the plan terminated, benefits payable under this Policy for that disability will be the lesser of: (a) the disability benefits that would have been payable under the Prior Plan; and (b) those provided by this Policy. Credit will be given for partial completion under the Prior Plan of Elimination Periods and partial satisfaction of pre-existing condition limitations.
- B. The Elimination Period under this Policy will be waived for a Disability which begins while the Employee is insured under this Policy if all of the following conditions are met:
1. The Disability results from the same or related causes as a Disability for which monthly benefits were payable under the Prior Plan;
 2. Benefits are not payable for the Disability under the Prior Plan solely because it is not in effect;
 3. An Elimination Period would not apply to the Disability if the Prior Plan had not ended;
 4. The Disability begins within 6 months of the Employee's return to Active Service and the Employee's insurance under this Policy is continuous from this Policy's Effective Date.
- C. Except for any amount of benefit in excess of a Prior Plan's benefits, the Pre-existing Condition Limitation will not apply to an Employee covered under a Prior Plan who satisfied the pre-existing condition limitation, if any, under that plan. If an Employee, covered under a Prior Plan, did not fully satisfy the pre-existing condition limitation of that plan, credit will be given for any time that was satisfied under the Prior Plan's pre-existing condition limitation.

Benefits will be determined based on the lesser of: (1) the amount of the gross disability benefit under the Prior Plan and any applicable maximums; and (2) those provided by this Policy.

If benefits are payable under the Prior Plan for the Disability, no benefits are payable under this Policy.

TL-005108

DESCRIPTION OF BENEFITS

The following provisions explain the benefits available under the Policy. Please see the Schedule of Benefits for the applicability of these benefits to each class of Insureds.

Disability Benefits

The Insurance Company will pay Disability Benefits if an Employee becomes Disabled while covered under this Policy. The Employee must satisfy the Elimination Period, be under the Appropriate Care of a Physician, and meet all the other terms and conditions of the Policy. He or she must provide the Insurance Company, at his or her own expense, satisfactory proof of Disability before benefits will be paid. The Disability Benefit is shown in the Schedule of Benefits.

The Insurance Company will require continued proof of the Employee's Disability for benefits to continue.

Elimination Period

The Elimination Period is the period of time an Employee must be continuously Disabled before Disability Benefits are payable. The Elimination Period is shown in the Schedule of Benefits.

A period of Disability is not continuous if separate periods of Disability result from unrelated causes.

Disability Benefit Calculation

The Disability Benefit Calculation is shown in the Schedule of Benefits. Monthly Disability Benefits are based on a 30 day period. They will be prorated if payable for any period less than a month. If an Employee is working while Disabled, the Disability Benefit Calculation will be the Return to Work Incentive.

Return to Work Incentive

The Return to Work Incentive is shown in the Schedule of Benefits. An Employee may work for wage or profit while Disabled. In any month in which the Employee works and a Disability Benefit is payable, the Return to Work Incentive applies.

The Insurance Company will, from time to time, review the Employee's status and will require satisfactory proof of earnings and continued Disability.

Minimum Benefit

The Insurance Company will pay the Minimum Benefit shown in the Schedule of Benefits despite any reductions made for Other Income Benefits. The Minimum Benefit will not apply if benefits are being withheld to recover an overpayment of benefits.

Other Income Benefits

An Employee for whom Disability Benefits are payable under this Policy may be eligible for benefits from Other Income Benefits. If so, the Insurance Company may reduce the Disability Benefits by the amount of such Other Income Benefits.

Other Income Benefits include:

1. any amounts received (or assumed to be received*) by the Employee or his or her dependents under:
 - the Canada and Quebec Pension Plans;
 - the Railroad Retirement Act;
 - any local, state, provincial or federal government disability or retirement plan or law payable for Injury or Sickness provided as a result of employment with the Employer;
 - any sick leave or salary continuation plan of the Employer;
 - any work loss provision in mandatory "No-Fault" auto insurance.
2. any Social Security disability or retirement benefits the Employee or any third party receives (or is assumed to receive*) on his or her own behalf or for his or her dependents; or which his or her dependents receive (or are assumed to receive*) because of his or her entitlement to such benefits.
3. any Retirement Plan benefits funded by the Employer. "Retirement Plan" means any defined benefit or defined contribution plan sponsored or funded by the Employer. It does not include an individual deferred compensation agreement; a profit sharing or any other retirement or savings plan maintained in addition to a defined benefit or other defined contribution pension plan, or any employee savings plan including a thrift, stock option or stock bonus plan, individual retirement account or 401(k) plan.
4. any proceeds payable under any franchise or group insurance or similar plan. If other insurance applies to the same claim for Disability, and contains the same or similar provision for reduction because of other insurance, the Insurance Company will pay for its pro rata share of the total claim. "Pro rata share" means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies.
5. any amounts received (or assumed to be received*) by the Employee or his or her dependents under any workers' compensation, occupational disease, unemployment compensation law or similar state or federal law payable for Injury or Sickness arising out of work with the Employer, including all permanent and temporary disability benefits. This includes any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted.
6. any amounts paid because of loss of earnings or earning capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined.

Dependents include any person who receives (or is assumed to receive*) benefits under any applicable law because of an Employee's entitlement to benefits.

*See the Assumed Receipt of Benefits provision.

Increases in Other Income Benefits

Any increase in Other Income Benefits during a period of Disability due to a cost of living adjustment will not be considered in calculating the Employee's Disability Benefits after the first reduction is made for any Other Income Benefits. This section does not apply to any cost of living adjustment for Disability Earnings.

Lump Sum Payments

Other Income Benefits or earnings paid in a lump sum will be prorated over the period for which the sum is given. If no time is stated, the lump sum will be prorated over five years.

If no specific allocation of a lump sum payment is made, then the total payment will be an Other Income Benefit.

Assumed Receipt of Benefits

The Insurance Company will assume the Employee (and his or her dependents, if applicable) are receiving benefits for which they are eligible from Other Income Benefits. The Insurance Company will reduce the Employee's Disability Benefits by the amount from Other Income Benefits it estimates are payable to the Employee and his or her dependents.

The Insurance Company will waive Assumed Receipt of Benefits, except for Disability Earnings for work the Employee performs while Disability Benefits are payable, if the Employee:

1. provides satisfactory proof of application for Other Income Benefits;
2. signs a Reimbursement Agreement;
3. provides satisfactory proof that all appeals for Other Income Benefits have been made unless the Insurance Company determines that further appeals are not likely to succeed; and
4. submits satisfactory proof that Other Income Benefits were denied.

The Insurance Company will not assume receipt of any pension or retirement benefits that are actuarially reduced according to applicable law, until the Employee actually receives them.

Social Security Assistance

The Insurance Company may help the Employee in applying for Social Security Disability Income (SSDI) Benefits, and may require the Employee to file an appeal if it believes a reversal of a prior decision is possible.

The Insurance Company will reduce Disability Benefits by the amount it estimates the Employee will receive, if the Employee refuses to cooperate with or participate in the Social Security Assistance Program.

Recovery of Overpayment

The Insurance Company has the right to recover any benefits it has overpaid. The Insurance Company may use any or all of the following to recover an overpayment:

1. request a lump sum payment of the overpaid amount;
2. reduce any amounts payable under this Policy; and/or
3. take any appropriate collection activity available to it.

The Minimum Benefit amount will not apply when Disability Benefits are reduced in order to recover any overpayment.

If an overpayment is due when the Employee dies, any benefits payable under the Policy will be reduced to recover the overpayment.

Successive Periods of Disability

A separate period of Disability will be considered continuous:

1. if it results from the same or related causes as a prior Disability for which benefits were payable; and
2. if, after receiving Disability Benefits, the Employee returns to work in his or her Regular Occupation for less than 6 consecutive months; and
3. if the Employee earns less than the percentage of Indexed Earnings that would still qualify him or her to meet the definition of Disability/Disabled during at least one month.

Any later period of Disability, regardless of cause, that begins when the Employee is eligible for coverage under another group disability plan provided by any employer will not be considered a continuous period of Disability.

For any separate period of disability which is not considered continuous, the Employee must satisfy a new Elimination Period.

LIMITATIONS

Limited Benefit Periods for Mental or Nervous Disorders

The Insurance Company will pay Disability Benefits on a limited basis during an Employee's lifetime for a Disability caused by, or contributed to by, any one or more of the following conditions. Once 24 monthly Disability Benefits have been paid, no further benefits will be payable for any of the following conditions.

- 1) Anxiety disorders
- 2) Delusional (paranoid) disorders
- 3) Depressive disorders
- 4) Eating disorders
- 5) Mental illness
- 6) Somatoform disorders (psychosomatic illness)

If, before reaching his or her lifetime maximum benefit, an Employee is confined in a hospital for more than 14 consecutive days, that period of confinement will not count against his or her lifetime limit. The confinement must be for the Appropriate Care of any of the conditions listed above.

Limited Benefit Periods for Alcoholism and Drug Addiction or Abuse

The Insurance Company will pay Disability Benefits on a limited basis during an Employee's lifetime for a Disability caused by, or contributed to by, any one or more of the following conditions. Once 24 monthly Disability Benefits have been paid, no further benefits will be payable for any of the following conditions.

- 1) Alcoholism
- 2) Drug addiction or abuse

If, before reaching his or her lifetime maximum benefit, an Employee is confined in a hospital for more than 14 consecutive days, that period of confinement will not count against his or her lifetime limit. The confinement must be for the Appropriate Care of any of the conditions listed above.

Pre-Existing Condition Limitation

The Insurance Company will not pay benefits for any period of Disability caused or contributed to by, or resulting from, a Pre-existing Condition. A "Pre-existing Condition" means any Injury or Sickness for which the Employee incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before his or her most recent effective date of insurance.

The Pre-existing Condition Limitation will apply to any added benefits or increases in benefits. This limitation will not apply to a period of Disability that begins after an Employee is covered for at least 12 months after his or her most recent effective date of insurance, or the effective date of any added or increased benefits.

TL-007500.00

ADDITIONAL BENEFITS

Rehabilitation During a Period of Disability

If the Insurance Company determines that a Disabled Employee is a suitable candidate for rehabilitation, the Insurance Company may require the Employee to participate in a Rehabilitation Plan and assessment at our expense. The Insurance Company has the sole discretion to approve the Employee's participation in a Rehabilitation Plan and to approve a program as a Rehabilitation Plan. The Insurance Company will work with the Employee, the Employer and the Employee's Physician and others, as appropriate, to perform the assessment, develop a Rehabilitation Plan, and discuss return to work opportunities.

The Rehabilitation Plan may, at the Insurance Company's discretion, allow for payment of the Employee's medical expense, education expense, moving expense, accommodation expense or family care expense while he or she participates in the program.

If an Employee fails to fully cooperate in all required phases of the Rehabilitation Plan and assessment without Good Cause, no Disability Benefits will be paid, and insurance will end.

TL-007501.00

Survivor Benefit

The Insurance Company will pay a Survivor Benefit if an Employee dies while Monthly Benefits are payable. The Employee must have been continuously Disabled before the first benefit is payable. These benefits will be payable for the Maximum Benefit Period for Survivor Benefits.

Benefits will be paid to the Employee's Spouse. If there is no Spouse, benefits will be paid in equal shares to the Employee's surviving Children. If there are no Spouse and no Children, benefits will be paid to the Employee's estate.

"Spouse" means an Employee's lawful spouse. "Children" means an Employee's unmarried children under age 21 who are chiefly dependent upon the Employee for support and maintenance. The term includes a stepchild living with the Employee at the time of his or her death.

TL-005107

TERMINATION OF DISABILITY BENEFITS

Benefits will end on the earliest of the following dates:

1. the date the Employee earns from any occupation, more than the percentage of Indexed Earnings set forth in the definition of Disability applicable to him or her at that time;
2. the date the Insurance Company determines he or she is not Disabled;
3. the end of the Maximum Benefit Period;
4. the date the Employee dies;
5. the date the Employee refuses, without Good Cause, to fully cooperate in all required phases of the Rehabilitation Plan and assessment;
6. the date the Employee is no longer receiving Appropriate Care;
7. the date the Employee fails to cooperate with the Insurance Company in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Benefits may be resumed if the Employee begins to cooperate fully in the Rehabilitation Plan within 30 days of the date benefits terminated.

TL-007502.00

EXCLUSIONS

The Insurance Company will not pay any Disability Benefits for a Disability that results, directly or indirectly, from:

1. suicide, attempted suicide, or self-inflicted injury while sane or insane.
2. war or any act of war, whether or not declared.
3. active participation in a riot.
4. commission of a felony.
5. the revocation, restriction or non-renewal of an Employee's license, permit or certification necessary to perform the duties of his or her occupation unless due solely to Injury or Sickness otherwise covered by the Policy.

In addition, the Insurance Company will not pay Disability Benefits for any period of Disability during which the Employee is incarcerated in a penal or corrections institution.

TL-007503.00

CLAIM PROVISIONS

Notice of Claim

Written notice, or notice by any other electronic/telephonic means authorized by the Insurance Company, must be given to the Insurance Company within 31 days after a covered loss occurs or begins or as soon as reasonably possible. If written notice, or notice by any other electronic/telephonic means authorized by the Insurance Company, is not given in that time, the claim will not be invalidated or reduced if it is shown that notice was given as soon as was reasonably possible. Notice can be given at our home office in Philadelphia, Pennsylvania or to our agent. Notice should include the Employer's Name, the Policy Number and the claimant's name and address.

Claim Forms

When the Insurance Company receives notice of claim, the Insurance Company will send claim forms for filing proof of loss. If claim forms are not sent within 15 days after notice is received by the Insurance Company, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof, or proof by any other electronic/telephonic means authorized by the Insurance Company, of the nature and extent of the loss.

Claimant Cooperation Provision

Failure of a claimant to cooperate with the Insurance Company in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Insurance Data

The Employer is required to cooperate with the Insurance Company in the review of claims and applications for coverage. Any information the Insurance Company provides in these areas is confidential and may not be used or released by the Employer if not permitted by applicable privacy laws.

Proof of Loss

Written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given to the Insurance Company within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given not more than one year after that 90 day period. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is provided outside of these time limits, the claim will be denied. These time limits will not apply while the person making the claim lacks legal capacity.

Written proof, or proof by any other electronic/telephonic means authorized by the Insurance Company, that the loss continues must be furnished to the Insurance Company at intervals required by us. Within 30 days of a request, written proof of continued Disability and Appropriate Care by a Physician must be given to the Insurance Company.

Time of Payment

Disability Benefits will be paid at regular intervals of not less frequently than once a month. Any balance, unpaid at the end of any period for which the Insurance Company is liable, will be paid at that time.

To Whom Payable

Disability Benefits will be paid to the Employee. If any person to whom benefits are payable is a minor or, in the opinion of the Insurance Company, is not able to give a valid receipt, such payment will be made to his or her legal guardian. However, if no request for payment has been made by the legal guardian, the Insurance Company may, at its option, make payment to the person or institution appearing to have assumed custody and support.

If an Employee dies while any Disability Benefits remain unpaid, the Insurance Company may, at its option, make direct payment to any of the following living relatives of the Employee: spouse, mother, father, children, brothers or sisters; or to the executors or administrators of the Employee's estate. The Insurance Company may reduce the amount payable by any indebtedness due.

Payment in the manner described above will release the Insurance Company from all liability for any payment made.

Physical Examination and Autopsy

The Insurance Company, at its expense, will have the right to examine any person for whom a claim is pending as often as it may reasonably require. The Insurance Company may, at its expense, require an autopsy unless prohibited by law.

Legal Actions

No action at law or in equity may be brought to recover benefits under the Policy less than 60 days after written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, has been furnished as required by the Policy. No such action shall be brought more than 3 years after the time satisfactory proof of loss is required to be furnished.

Time Limitations

If any time limit stated in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity, is less than that permitted by the law of the state in which the Employee lives when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that state.

Physician/Patient Relationship

The Insured will have the right to choose any Physician who is practicing legally. The Insurance Company will in no way disturb the Physician/patient relationship.

TL-004724

ADMINISTRATIVE PROVISIONS

Premiums

The premiums for this Policy will be based on the rates currently in force, the plan and the amount of insurance in effect.

Changes in Premium Rates

The premium rates may be changed by the Insurance Company from time to time with at least 31 days advance written notice. No change in rates will be made until 36 months after the Effective Date. An increase in rates will not be made more often than once in a 12 month period. However, the Insurance Company reserves the right to change the rates even during a period for which the rate is guarantee, if any of the following events take place.

1. The Policy terms change.
2. A division, subsidiary, eligible company, or class is added or deleted.
3. There is a change of more than 10% in the number of Insureds.
4. Federal or state laws or regulation affecting benefit obligations change.
5. Other changes occur in the nature of the risk that would affect the Insurance Company's original risk assessment.
6. The Insurance Company determines the Employer fails to furnish necessary information.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a pro rata adjustment will apply from the date of the change to the next Premium Due Date.

Reporting Requirements

The Employer must, upon request, give the Insurance Company any information required to determine who is insured, the amount of insurance in force and any other information needed to administer the plan of insurance.

Payment of Premium

The first premium is due on the Policy Effective Date. After that, premiums will be due monthly unless the Employer and the Insurance Company agree on some other method of premium payment.

If any premium is not paid when due, the plan will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Notice Of Cancellation

The Employer or the Insurance Company may cancel the policy as of any Premium Due Date by giving 31 days advance written notice. If a premium is not paid when due, the Policy will automatically be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Policy Grace Period

A Policy Grace Period of 31 days will be granted for the payment of the required premiums under this Policy. This Policy will be in force during the Policy Grace Period. The Employer is liable to the Insurance Company for any unpaid premium for the time this Policy was in force.

Reinstatement of Insurance

An Employee's insurance may be reinstated if it ends because he or she is on an unpaid leave of absence. If an Employee's Active Service ended due to an approved leave pursuant to the Family and Medical Leave Act (FMLA) and Continuation of Insurance is not applicable, an Employee's insurance may be reinstated at the conclusion of the FMLA leave.

If an Employee's Active Service ends due to an Employer approved unpaid leave of absence, other than an approved FMLA leave, insurance may be reinstated only:

1. If the reinstatement occurs within 12 weeks from the date insurance ends, or
2. When returning from military service pursuant to the Uniformed Services Employment Act of 1994 (USERRA).

For insurance to be reinstated the following conditions must be met:

1. An Employee must be in a Class of Eligible Employees.
2. The required premium must be paid.
3. The Insurance Company must receive a written request for reinstatement within 31 days from the date an Employee returns to Active Service.

Reinstated insurance will be effective on the date the Employee returns to Active Service. If an Employee did not fully satisfy the Eligibility Waiting Period or the Pre-Existing Condition Limitation (if any) before insurance ended due to an unpaid leave of absence or Temporary Layoff, credit will be given for any time that was satisfied.

TL-009960.00

GENERAL PROVISIONS

Entire Contract

The entire contract will be made up of the Policy, the application of the Employer, a copy of which is attached to the Policy, and the applications, if any, of the Insureds.

Incontestability

All statements made by the Employer or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement has been furnished to the claimant. In the event of death or legal incapacity, the beneficiary or representative must receive the copy.

After two years from an Insured's effective date of insurance, or from the effective date of any added or increased benefits, no such statement will cause insurance to be contested except for fraud or eligibility for coverage.

Misstatement of Age

If an Insured's age has been misstated, the Insurance Company will adjust all benefits to the amounts that would have been purchased for the correct age.

Policy Changes

No change in the Policy will be valid until approved by an executive officer of the Insurance Company. This approval must be endorsed on, or attached to, the Policy. No agent may change the Policy or waive any of its provisions.

Workers' Compensation Insurance

The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance Law.

Certificates

A certificate of insurance will be delivered to the Employer for delivery to Insureds. Each certificate will list the benefits, conditions and limits of the Policy. It will state to whom benefits will be paid.

Assignment of Benefits

The Insurance Company will not be affected by the assignment of an Insured's certificate until the original assignment or a certified copy of the assignment is filed with the Insurance Company. The Insurance Company will not be responsible for the validity or sufficiency of an assignment. An assignment of benefits will operate so long as the assignment remains in force provided insurance under the Policy is in effect. This insurance may not be levied on, attached, garnisheed, or otherwise taken for a person's debts. This prohibition does not apply where contrary to law.

Clerical Error

A person's insurance will not be affected by error or delay in keeping records of insurance under the Policy. If such an error is found, the premium will be adjusted fairly.

Agency

The Employer and Plan Administrator are agents of the Employee for transactions relating to insurance under the Policy. The Insurance Company is not liable for any of their acts or omissions.

Ownership of Records

All records maintained by the Insurance Company are, and shall remain, the property of the Insurance Company.

TL-004726

Certain Internal Revenue Code (IRC) & Internal Revenue Service (IRS) Functions

The Insurer may agree with the Policyholder to perform certain functions required by the Internal Revenue Code and IRS regulations. Such functions may include the preparation and filing of wage and tax statements (Form W-2) for disability benefit payments made under this Policy. In consideration of the payment of premiums by the Policyholder, the Insurer waives the right to transfer liability with respect to the employer taxes imposed on the Insurer by IRS Regulation 32.1(e)(1) for monthly Disability payments made under this Policy. Employee money may not be used to fund the Premium for the services and payments of this section.

TL-009230.00

DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout this document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

Active Service

An Employee is in Active Service on a day which is one of the Employer's scheduled work days if either of the following conditions are met.

1. The Employee is performing his or her regular occupation for the Employer on a full-time basis. He or she must be working at one of the Employer's usual places of business or at some location to which the employer's business requires an Employee to travel.
2. The day is a scheduled holiday or vacation day and the Employee was performing his or her regular occupation on the preceding scheduled work day.

An Employee is in Active Service on a day which is not one of the Employer's scheduled work days only if he or she was in Active Service on the preceding scheduled work day.

Appropriate Care

Appropriate Care means the Employee:

1. Has received treatment, care and advice from a Physician who is qualified and experienced in the diagnosis and treatment of the conditions causing Disability. If the condition is of a nature or severity that it is customarily treated by a recognized medical specialty, the Physician is a practitioner in that specialty.
2. Continues to receive such treatment, care or advice as often as is required for treatment of the conditions causing Disability.
3. Adheres to the treatment plan prescribed by the Physician, including the taking of medications.

Consumer Price Index (CPI-W)

The Consumer Price Index for Urban Wage Earners and Clerical Workers published by the U.S. Department of Labor. If the index is discontinued or changed, another nationally published index that is comparable to the CPI-W will be used.

Disability Earnings

Any wage or salary for any work performed for any employer during the Employee's Disability, including commissions, bonus, overtime pay or other extra compensation.

Employee

For eligibility purposes, an Employee is an employee of the Employer in one of the "Classes of Eligible Employees." Otherwise, Employee means an employee of the Employer who is insured under the Policy.

Employer

The Policyholder and any affiliates or subsidiaries covered under the Policy. The Employer is acting as an agent of the Insured for transactions relating to this insurance. The actions of the Employer shall not be considered the actions of the Insurance Company.

Full-time

Full-time means the number of hours set by the Employer as a regular work day for Employees in the Employee's eligibility class.

Furlough

Furlough means a temporary suspension or alteration of Active Service initiated by the Employer, for a period of time specified in advance not to exceed 30 days at a time.

Good Cause

A medical reason preventing participation in the Rehabilitation Plan. Satisfactory proof of Good Cause must be provided to the Insurance Company.

Indexed Earnings

For the first 12 months Monthly Benefits are payable, Indexed Earnings will be equal to Covered Earnings. After 12 Monthly Benefits are payable, Indexed Earnings will be an Employee's Covered Earnings plus an increase applied on each anniversary of the date Monthly Benefits became payable. The amount of each increase will be the lesser of:

1. 10% of the Employee's Indexed Earnings during the preceding year of Disability; or
2. the rate of increase in the Consumer Price Index (CPI-W) during the preceding calendar year.

Injury

Any accidental loss or bodily harm which results directly and independently of all other causes from an Accident.

Insurability Requirement

An eligible person will satisfy the Insurability Requirement for an amount of coverage on the day the Insurance Company agrees in writing to accept him or her as insured for that amount. To determine a person's acceptability for coverage, the Insurance Company will require evidence of good health and may require it be provided at the Employee's expense.

Insurance Company

The Insurance Company underwriting the Policy is named on the Policy cover page.

Insured

A person who is eligible for insurance under the Policy, for whom insurance is elected, the required premium is paid and coverage is in force under the Policy.

Physician

Physician means a licensed doctor practicing within the scope of his or her license and rendering care and treatment to an Insured that is appropriate for the condition and locality. The term does not include an Employee, an Employee's spouse, the immediate family (including parents, children, siblings or spouses of any of the foregoing, whether the relationship derives from blood or marriage), of an Employee or spouse, or a person living in an Employee's household.

Prior Plan

The Prior Plan refers to the plan of insurance providing similar benefits sponsored by the Employer in effect directly prior to the Policy Effective Date. A Prior Plan will include the plan of a company in effect on the day prior to that company's addition to this Policy after the Policy Effective Date.

Regular Occupation

The occupation the Employee routinely performs at the time the Disability begins. In evaluating the Disability, the Insurance Company will consider the duties of the occupation as it is normally performed in the general labor market in the national economy. It is not work tasks that are performed for a specific employer or at a specific location.

Rehabilitation Plan

A written plan designed to enable the Employee to return to work. The Rehabilitation Plan will consist of one or more of the following phases:

1. rehabilitation, under which the Insurance Company may provide, arrange or authorize educational, vocational or physical rehabilitation or other appropriate services;
2. work, which may include modified work and work on a part-time basis.

Sickness

Any physical or mental illness.

Temporary Layoff

Temporary Layoff means a temporary suspension of Active Service for a period of time determined in advance by the Employer, other than a Furlough as defined. Temporary Layoff does not include the permanent termination of Active Service (including but not limited to a job elimination), which shall be treated as termination of employment.

TL-007500.00 as modified by TL-009980

IMPORTANT CHANGES FOR STATE REQUIREMENTS

If an Employee resides in one of the following states, the provisions of the certificate are modified for residents of the following states. The modifications listed apply only to residents of that state.

Louisiana residents:

The percentage of Indexed Earnings, if any, that qualifies an insured to meet the definition of Disability/Disabled may not be less than 80%.

Massachusetts residents:

Continuation of Insurance after leaving the group

If an Employee leaves the group covered under the Policy, insurance for such Employee will be continued until the earliest of the following dates:

1. 31 days from the date the Employee leaves the group;
2. The date the Employee becomes eligible for similar benefits.

Continuation of Insurance due to a Plant Closing or Partial Closing

If an Employee leaves the group due to termination of employment resulting from a Plant Closing or Partial Closing, insurance for such Employee will be continued until the earliest of the following dates:

1. 90 days from the date of the Plant Closing or Partial Closing;
2. The date the Employee becomes eligible for similar benefits.

Definitions : For purposes of this provision:

Plant Closing means a permanent cessation or reduction of business at a facility which results or will result as determined by the director in the permanent separation of at least 90% of the employees of said facility within a period of six months prior to the date of certification or with such other period as the director shall prescribe, provided that such period shall fall within the six month period prior to the date of certification.

Partial Closing means a permanent cessation of a major discrete portion of the business conducted at a facility which results in the termination of a significant number of the employees of said facility and which affects workers and communities in a manner similar to that of Plant Closings.

Minnesota residents:

The Pre-existing Condition Limitation, if any, may not be longer than 24 months from the insured's most recent effective date of insurance.

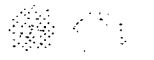
Texas residents:

Any provision offsetting or otherwise reducing any benefit by an amount payable under an individual or franchise policy will not apply.

Washington residents:

The following definition of "Children" as stated under the Survivor Benefit is applicable to Washington residents.

"Children" means an Employee's children under age 26 who are chiefly dependent upon the Employee for support and maintenance.



**LIFE INSURANCE COMPANY OF NORTH AMERICA
PHILADELPHIA, PA 19192-2235**

We, Jackson County Memorial Hospital, whose main office address is Altus, OK, hereby approve and accept the terms of Group Policy Number LK-963732 issued by the LIFE INSURANCE COMPANY OF NORTH AMERICA. We acknowledge that benefits will be provided in accordance with the terms and provisions of the policy, which will be the sole contract under which benefits are paid.

This form is to be signed in duplicate. One part is to be retained by Jackson County Memorial Hospital; the other part is to be returned to the LIFE INSURANCE COMPANY OF NORTH AMERICA.

Jackson County Memorial Hospital

Signature and Title: _____ Date: _____

(This Copy Is To Be Returned To LIFE INSURANCE COMPANY OF NORTH AMERICA)

**LIFE INSURANCE COMPANY OF NORTH AMERICA
PHILADELPHIA, PA 19192-2235**

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Jackson County Memorial Hospital

Signature and Title: _____ Date: _____

(This Copy Is To Be Retained By Jackson County Memorial Hospital)

NOTICE

NOTICE OF PROTECTION
PROVIDED BY
OKLAHOMA LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION

WARNING:

Any person who knowingly, and with intent to injure, defraud or deceive any Insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

This notice provides a brief summary of the Oklahoma Life and Health Insurance Guaranty Association ("The Association") and the protection it provides for policyholders. This safety net was created under Oklahoma law, which determines who and what is covered and the amounts of coverage. The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Oklahoma law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- **Life Insurance**
 - \$300,000 in death benefits
 - \$100,000 in cash surrender or withdrawal values
- **Health Insurance**
 - \$500,000 in hospital, medical and surgical insurance benefits
 - \$300,000 in disability income insurance benefits
 - \$300,000 in long-term care insurance benefits
 - \$100,000 in other types of health insurance benefits
- **Annuities**
 - \$300,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000, except that with regard to hospital, medical and surgical insurance benefits, the maximum amount that will be paid is \$500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Oklahoma law.

To learn more about the above protections, please visit the Association's website at www.oklifega.org, or contact:

Oklahoma Life & Health Insurance Guaranty Association
201 Robert S. Kerr, Suite 600
Oklahoma City, OK 73102
Phone: (405) 272-9221

Oklahoma Department of Insurance
3625 NW 56th Street, Suite 100
Oklahoma City, OK 73112
1-800-522-0071 or (405) 521-2828

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Casandra
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ANGELIA ANDREWS
402 EAST 13TH ST.
CLAREMORE, OK 74017

June 16, 2016

Name: Angelia Andrews
Incident Number: 3465490-01
Policy Number: LK -0963732
Policy Name: Jackson County Memorial Hospital
Underwriting Company: Life Insurance Co of North America

Dear Ms Andrews:

This letter is regarding your Long Term Disability (LTD) claim. We have conducted an evaluation to determine your eligibility for benefits beyond October 8, 2016 which is when your policy's definition of disability changes.

We have completed our review and determined that you no longer remain disabled as defined by your policy. As you are aware, under the terms of the policy, Disability is defined as:

According to your employer's disability policy:

Definition of Disability/Disabled

"The Employee is considered Disabled if, solely because of Injury or Sickness, he or she is:

- 1. unable to perform the material duties of his or her Regular Occupation; and*
- 2. unable to earn 80% or more of his or her Indexed Earnings from working in his or her Regular Occupation.*

After Disability Benefits have been payable for 24 months, the Employee is considered Disabled if, solely due to Injury or Sickness, he or she is:

- 1. unable to perform the material duties of any occupation for which he or she is, or may reasonably become, qualified based on education, training or experience; and*
- 2. unable to earn 80% or more of his or her Indexed Earnings.*

The Insurance Company will require proof of earnings and continued Disability."

Who Reviewed Your Claim?

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- LTD Claim Manager
- Senior Claim Manager
- Nurse Case Manager
- Behavioral Health Specialist
- Orthopedic Medical Director
- Psychiatric Medical Director
- Vocational Rehabilitation Specialist

What Information Was Reviewed?

Our review of the information on file specifically included:

- Medical records from Dr. Macias dated May 02, 2016 through July 15, 2015 including a Physical Abilities assessment dated May 17, 2016
- Medical records from Dr. Nouh dated November 23, 2015 through May 4, 2016
- Medical records from Dr. Cross dated January 13, 2016
- Medical records from Dr. Karnama dated February 26, 2016
- Medical records from Dr. Marshal dated February 12, 2016
- Medical records from Dr. Ichinose dated February 26, 2016 through January 11, 2016
- Medical records from Dr. Bower dated November 23, 2015
- Medical records from Dr. Kunapuli dated September 17, 2015 through October 8, 2015 including a Physical Abilities Assessment completed January 17, 2016
- Medical Records from Performance Physical Therapy dated September 05, 2015 through October 27, 2015

How Was the Claim Decision Reached?

Based on the provided medical information it was determined that you are capable of performing 8 hours a day and 40 hours a week with restrictions of no heavy lifting, pushing, or pulling above 15 pounds, no stooping, no crawling and steps should only be used occasionally, with no restrictions on sitting, standing, or walking, reaching, grasping and fine manipulation.

We then referred your claim to our vocational department for review for a Transferable Skills Analysis. They considered your work capacity, restrictions and limitations, along with your education and employment history, to determine occupations that you would be able to perform based on your current work experience.

This review confirmed that you would be able to perform the following occupation:

- MD Consultant – 070.101-026

The above identified occupations are compatible with your work capacity. Additionally, the jobs listed above satisfies the earnings requirement for your Indexed Covered Earnings under the policy.

At this time you no longer meet the definition of disability stated about and your claim has been closed. Payments have been made through October 07, 2016 and no further benefits are due.

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How Was Your Social Security Award Considered in the Claim Decision?

We are aware that you have been awarded Social Security Disability Insurance (SSDI) benefits by the Social Security Administration (SSA), and have considered that fact in our claim review. The criteria used by the SSA may differ from the requirements of your Employer's LTD policy.

What If You Don't Agree With The Claim Decision?

If you disagree with our determination and wish to have it reviewed, please follow the steps described below.

Based on the information provided by your Employer, your claim is governed by the Employee Retirement Income Security Act of 1974, Public Law 93-406 (ERISA). ERISA requires that you go through the Company's administrative appeal review process prior to pursuing any legal action challenging our claim determination.

Here's how to submit your administrative appeal review request:

- Submit your appeal letter to us within 180 days of your receipt of this letter.
- Your appeal letter should be sent to the Life Insurance Co of North America representative signing this letter to the address noted on the letterhead.
- Your appeal letter may include written comments as well as any new information you may have.
- You may also submit additional information. Additional information may include, but is not limited to: medical records from your doctor and/or hospital, test result reports, therapy notes, etc. These medical records should cover the period of October 08, 2016 and forward.
- You may also wish to have your doctor(s) provide some or all of the following:
 - A complete list of your current treating physicians.
 - A discussion by your treating physician (s) describing your current and future treatment plan (s). What are the problems of treatment? What are the treatment goals (clinical and measurable)? What are the treatment strategies for each goal? How does the treatment plan address your return to work?
 - A discussion by your treating physician (s) of the medical evidence pointing to a condition that prevents you from performing all the material duties of your own occupation. What are the current data sources used to make this determination?
 - Any new outpatient or inpatient programs that you are attending and corresponding therapy notes from them
 - Completed Disability Questionnaire
 - Copies of other diagnostic test results which document the severity of your condition to the extent that you are unable to perform the duties of your occupation, Please include the copies of recent test results performed (in the last 6 months).
 - Copies of treatment notes, office notes, physical therapy notes and or consultation reports.
 - Functional Capacity Evaluation
 - Neuropsych Testing/Independent Medical Examination

You have the right to bring a legal action for benefits under the Employee Retirement Income Security Act of 1974 (ERISA) section 502(a) following an adverse benefit determination on appeal.

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Nothing contained in this letter should be construed as a waiver of any rights or defenses under the policy. This determination has been made in good faith and without prejudice under the terms and conditions of the policy, whether or not specifically mentioned herein. Should you have any information which would prove contrary to our findings, please submit it to us. We will be pleased to review any information you may wish to submit.

Please be aware that you are entitled to receive, upon request and free of charge, information relevant to your claim for benefits.

Please contact our office at 800.352.0611 should you have any questions.

Sincerely,



Casandra
Group Claims Associate

John
Cigna
PO Box 29221
Phoenix, AZ 85038-9221

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JAMES W. DUNHAM, JR. - ATTORNEY AT LAW
15 WEST 6TH STREET
STE 2112
BANK OF AMERICA CENTER
TULSA, OK 74119

January 30, 2017

Name: Angelia Andrews
Incident Number: 3465490-01
Policy Number: LK-0963732
Policy Name: Jackson County Memorial Hospital
Underwriting Company: Life Insurance Co of North America

Dear Mr Dunham, Jr. - Attorney At Law:

This letter is regarding the appeal on your client's Long Term Disability (LTD) claim. We have separated this letter into subject headings for your ease of reference.

Will You Receive/Continue to Receive Disability Benefits?

We have carefully reviewed your client's claim for Long Term Disability (LTD) benefits and we have overturned the previous denial of your client's claim for a closed period of time.

What Provisions of the Disability Contract Apply to the Decision on Your Claim?

Definition of Disability/Disabled

"The Employee is considered Disabled if, solely because of Injury or Sickness, he or she is:

- 1. unable to perform the material duties of his or her Regular Occupation; and*
- 2. unable to earn 80% or more of his or her Indexed Earnings from working in his or her Regular Occupation.*

After Disability Benefits have been payable for 24 months, the Employee is considered Disabled if, solely due to Injury or Sickness, he or she is:



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1. unable to perform the material duties of any occupation for which he or she is, or may reasonably become, qualified based on education, training or experience; and
2. unable to earn 80% or more of his or her Indexed Earnings.

The Insurance Company will require proof of earnings and continued Disability."

Limited Benefit Periods for Mental or Nervous Disorders

"The Insurance Company will pay Disability Benefits on a limited basis during an Employee's lifetime for a Disability caused by, or contributed to by, any one or more of the following conditions. Once 24 monthly Disability Benefits have been paid, no further benefits will be payable for any of the following conditions.

- 1) Anxiety disorders
- 2) Delusional (paranoid) disorders
- 3) Depressive disorders
- 4) Eating disorders
- 5) Mental illness
- 6) Somatoform disorders (psychosomatic illness)

If, before reaching his or her lifetime maximum benefit, an Employee is confined in a hospital for more than 14 consecutive days, that period of confinement will not count against his or her lifetime limit. The confinement must be for the Appropriate Care of any of the conditions listed above."

What Information Was Reviewed?

We based our decision on your client's claim for benefits upon Policy language and all documents contained in her claim file, viewed as a whole.

Who Reviewed Your Claim?

Appeals Specialist
Senior Appeals Specialist
Medical Doctor Board Certified in Neurology
Medical Doctor Board Certified in Neuropsychology

How was the Claim Decision Reached?

To clarify your functionality, we referred your file for an independent medical review by a physician that is board certified in Neurology as well as a physician that is board certified in Neuropsychology. The physicians reviewed all of the medical documentation contained in your claim file.

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The physician that is board certified in Neurology opined there was no clear evidence of a physical function limitation from October 8, 2016 and continuing. During that time frame and immediately preceding, your client was followed by Dr. Nouh, without a documented neurological examination supporting the presence of an impairment. The most recent completed physical examination on May 2, 2016 revealed no abnormalities. There were no objective correlates to support the presence of any ongoing neurological impairment, and there was therefore no objective evidence that your client had any neurological impairment that would have translated to restrictions and limitations. Based on a lack of objective findings supporting the presence of a neurological impairment, no medically necessary work activity restrictions were required.

The physician that is board certified in Neuropsychology opined your client has had numerous treatments including psychotherapy and pharmaceutical intervention for her pain and her psychiatric diagnoses with little result. That supported the presence of validated mental health difficulties which would have precluded continuous gainful employment.

Your client had a neuropsychological evaluation done on November 4, 2016 by Dr. Faust Bianco as a result of a referral by her attorney. She had complaints of depression, anxiety, chronic pain, neuropathy, memory problems, sustained attention and concentration, information processing, word finding and mental abstraction. These concerns were corroborated by her caregiver/ex-husband. Symptom validity tests indicated good effort. She was not easily distracted by external stimuli and visual perception appeared normal. Visual memory showed some impairment and verbal memory performance was inconsistent. Language was generally intact, but she had some difficulty when rapidly naming colors. Multitasking and planning were intact, but she had some difficulty with response inhibition. Her response patterns on objective measures of personality functioning were consistent with somatic concerns, marked distress and depression and anxiety.

The first documented indication of mental health difficulties which would have precluded your client's return to work was October 23, 2014 and Dr. Ballard indicated she had complete limitations on working due to permanent spinal injury with constant pain treated with narcotics which would have precluded her making critical medical decisions. This would have also been supported by Dr. Duncan's note of October 27, 2014 where it was noted she had poor stamina and chronic pain. She had complaints of "jumping" in her muscles, and had a 10% decrease in pain after using amitriptyline and fentanyl patch.

After review of the entirety of the medical documentation contained in the file, our assessment is that your client would have been entitled to benefits from October 8, 2016 through October 22, 2016, as the medical evidence on file supported your client's

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inability to perform the material duties of her regular occupation through October 22, 2016. Therefore benefits would have been payable to October 22, 2016.

Based on the policy Limited Benefit Periods for Mental or Nervous Disorders provision benefits were payable for 24 months. Therefore benefits were payable for the Period of October 23, 2014 through October 22, 2016.

Your client's claim file has been returned to the previous Case Manager handling her claim for issuance of her full and final benefits. No further Benefits are due at this time.

What If You Do Not Agree With This Appeal Decision?

If you disagree with our determination and wish to have it reviewed, please follow the steps described below.

- Submit your appeal letter to us within 180 days of your receipt of this letter.
- Your appeal letter should be sent to the Life Insurance Company of North America representative signing this letter to the address noted on the letterhead.
- Your appeal letter may include written comments as well as any new information you may have.
- Copies of any other diagnostic test results (such as -- MRI/X-Ray) that document a sufficient degree of severity in your client's condition to render her unable to perform the material duties of any occupation. In the absence of this documentation, we shall assume any such reports revealed normal findings and unimpaired function.
- Copies of treatment notes, office notes, physical therapy notes and/or consultation reports for the period of January 1, 2016, through the present that we may not have on file.
- A discussion by your client's treating physician(s) of the medical evidence pointing to a condition that prevents her from performing the material duties of any occupation. What are the current data sources used to make this determination?
- A discussion by your client's treating physician(s) describing her current and future treatment plan(s). What are the problems of treatment? What are the treatment goals (clinical and measurable)? What are the treatment strategies for each goal? How does the treatment plan address your client's return to work?

Please be advised that the Policy under which you are insured states the following:

Legal Actions

"No action at law or in equity may be brought to recover benefits under the Policy less than 60 days after written proof of loss, or proof by any other electronic/telephonic means

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authorized by the Insurance Company, has been furnished as required by the Policy. No such action shall be brought more than 3 years after the time satisfactory proof of loss is required to be furnished."

Time Limitations

"If any time limit stated in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity, is less than that permitted by the law of the state in which the Employee lives when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that state."

Nothing contained in this letter should be construed as a waiver of any rights or defenses under the Policy. This determination has been made in good faith and without prejudice under the terms and conditions of the Policy, whether or not specifically mentioned herein.

Please review your client's insurance booklet, certificate or coverage information available from her employer to determine if she is eligible for additional benefits. Upon written request, you may receive a copy of your client's claim file, free of charge.

Please contact our office at 800.352.0611 should you have any questions.

Sincerely,

A handwritten signature in cursive script that reads "John".

John
Appeal Specialist